



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

South Texas Health System

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-10-4171-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

May 25, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...they have not paid what we determine is the correct allowable per the APC allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account. Per the new fee schedule this account qualifies for an Outlier payment..."

Amount in Dispute: \$1,064.23

Respondent's Position Summary: "To clarify, only one facet injection code should be reported at a specified level and side injected (e.g., right L4-5 facet joint), regardless of the number of needle(s) inserted or number of drug(s) injected at that specific level."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 3 – 9, 2009	Outpatient Hospital Services	\$1,064.23	\$1,064.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – Z547 – This bill was reviewed in accordance with your fee for service contract with First Health.
 - 42 – Z710 – The charge for this procedure exceeds the fee schedule allowance.
 - 16 - X936 – CPT or HCPC is required to determine if services are payable.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?

3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415, date of service June 3, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Procedure code 80053, date of service June 3, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$15.44. 125% of this amount is \$19.30
 - Procedure code 82962, date of service May 8, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.42. This amount multiplied by 2 units is \$6.84. 125% of this amount is \$8.55
 - Procedure code 85025, date of service June 3, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.35. 125% of this amount is \$14.19
 - Procedure code 81001, date of service June 3, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.63. 125% of this amount is \$5.79

- Procedure code 71020, date of service June 5, 2009, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.82. This amount multiplied by the annual wage index for this facility of 0.9118 yields an adjusted labor-related amount of \$24.45. The non-labor related portion is 40% of the APC rate or \$17.88. The sum of the labor and non-labor related amounts is \$42.33. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$42.33. This amount multiplied by 200% yields a MAR of \$84.66.
- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 64475 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of \$473.78. This amount multiplied by 60% yields an unadjusted labor-related amount of \$284.27. This amount multiplied by the annual wage index for this facility of 0.9118 yields an adjusted labor-related amount of \$259.20. The non-labor related portion is 40% of the APC rate or \$189.51. The sum of the labor and non-labor related amounts is \$448.71. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$673.07 divided by the sum of all S and T APC payments of \$853.39 gives an APC payment ratio for this line of 0.7887, multiplied by the sum of all S and T line charges of \$6,294.00, yields a new charge amount of \$4,964.08 for the purpose of outlier calculation.

The provider billed this service with modifier 50. Review of the medical record finds, "...medial branch block on the left at L4 and L5. We accomplished this under C-arm control, injecting 1.5 ml of Marcaine and Depo-Medrol at each level... We accomplished the same injection on the right side at L4-5 and L5-S1 and injected the remainder of the barrel of Depo-Medrol and plain Marcaine and Xylocaine plain as well preservative free into the medial branch block regions with a good result." The bi-lateral procedure modifier is supported.

Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is \$673.07. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of \$4,964.08 yields a cost of \$1,180.95. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$673.07 divided by the sum of all APC payments is 75.14%. The sum of all packaged costs is \$1,340.72. The allocated portion of packaged costs is \$1,007.45. This amount added to the service cost yields a total cost of \$2,188.40. The cost of these services exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$1,010.54. 50% of this amount is \$505.27. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$1,178.34. This amount multiplied by 200% yields a MAR of \$2,356.67.

- Procedure code 64476, date of service June 9, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0204, which, per OPPS Addendum A, has a payment rate of \$164.30. This amount multiplied by 60% yields an unadjusted labor-related amount of \$98.58. This amount multiplied by the annual wage index for this facility of 0.9118 yields an adjusted labor-related amount of \$89.89. The non-labor related portion is 40% of the APC rate or \$65.72. The sum of the labor and non-labor related amounts is \$155.61. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge

amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$155.61 divided by the sum of all S and T APC payments of \$853.39 gives an APC payment ratio for this line of 0.182344, multiplied by the sum of all S and T line charges of \$6,294.00, yields a new charge amount of \$1,147.67 for the purpose of outlier calculation. The provider billed this service with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is \$155.61. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$155.61. This amount multiplied by 200% yields a MAR of \$311.22.

- Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250, date of service June 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010, date of service June 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 93005, date of service June 5, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$26.09. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.65. This amount multiplied by the annual wage index for this facility of 0.9118 yields an adjusted labor-related amount of \$14.27. The non-labor related portion is 40% of the APC rate or \$10.44. The sum of the labor and non-labor related amounts is \$24.71. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$24.71 divided by the sum of all S and T APC payments of \$853.39 gives an APC payment ratio for this line of 0.028955, multiplied by the sum of all S and T line charges of \$6,294.00, yields a new charge amount of \$182.24 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$24.71. This amount multiplied by 200% yields a MAR of \$49.42.
4. The total allowable reimbursement for the services in dispute is \$2,853.55. The amount previously paid by the insurance carrier is \$1,768.37. The requestor is seeking additional reimbursement in the amount of \$1,064.23. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,064.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,064.23, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 6, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.